Cross-cutting Issue 2: Model Array of Statewide Services—Mental Illness and Emotional Disorders

The development of a model continuum for publicly funded mental health services is one of the most important tasks the Mental Health Commission has undertaken. Ideally, a continuum should exist within an overall framework that includes:

- a recognition that recovery from mental illness involves varying degrees of service requirements, progress, and potential setbacks over time;
- screening for mental, emotional, and substance abuse disorders in primary care and other human service settings across the life span;
- access to culturally competent, quality care throughout the state;
- the use of evidence-based practices; and
- the active involvement of consumers and their families.

Following this issue brief is a draft model continuum. The first three of its four sections (Mental Health Treatment and Support; Systems Coordination; and Administrative Support for Constituent Services) were developed collaboratively in 1999–2000 by two consumer advocates and representatives of 11 statewide organizations.[2] (In fact, six voting members of the Mental Health Commission were directly involved in the development.) Because prevention services were outside the purview of the effort undertaken in 1999–2000, a fourth and final section on prevention has been added for commission consideration.

It is suggested that this document serve as a starting point for a model continuum ultimately emanating from the commission. While the attachment is not divided by age groupings, it was designed to incorporate all requirements that might come into play for minors, non-geriatric adults and seniors. (With the addition of a prevention section, the continuum appears to cover everything recommended in the children's work group draft continuum.)

It is further suggested that, once a continuum is finalized, the commission recommend that all its components be available within 60 miles of a recipient's residence, and that the Department of Community Health (DCH) assure that standards and practice guidelines are developed for each.

Most of the items in the draft model continuum can be found somewhere in Michigan's public mental health system, but not necessarily within each CMHSP catchment area. There is considerable variation among some items regarding degree of accessibility. Michigan has been a national leader in quantity of Assertive Community Treatment (ACT) programming and the development of person-centered planning policies; many clubhouse programs have been established across the state; and DCH's current efforts toward greater integration of mental illness and substance abuse service are promising.

[2] Association for Children's Mental Health; Mental Health Association in Michigan; Michigan Association for Children with Emotional Disorders; Michigan Association of Community Mental Health Boards; Michigan Department of Community Health; Michigan Health and Hospital Association; Michigan Protection and Advocacy Service; Michigan Psychiatric Society; Michigan Psychological Association; Michigan State Medical Society; National Alliance for the Mentally Ill-Michigan.

On the other hand, access to inpatient care has been problematic (most especially, but not exclusively, regarding intermediate and longer-term options); there are relatively few residential beds for adult and child mental illness available through the public mental health system (as well as other housing difficulties); evidence is lacking of persons being diverted from justice system incarceration in significant numbers; less than half of mental illness consumers (adult and child) internally categorized as "serious" by DCH receive case management; relatively few children receive wraparound programming; counseling/ therapy may be restricted primarily to short-term duration; and legislative appropriations for multicultural and pilot prevention programming have been very small or nonexistent (prevention line defunded since 2001).

Working toward and ultimately having in place a comprehensive statewide continuum can truly position Michigan as an exemplary state for national emulation.

Draft Model Continuum
Publicly Funded Service for Mental Illnesses and Emotional Disorders

I. *Mental Health Treatment and Support*

A. Mental Health Clinic Services

1. Identification of recipient needs by screening, assessment, and diagnosis
2. Development of an individualized service plan[1]
3. Psychiatric evaluation; face-to-face assessment with a Board-eligible, Board-certified psychiatrist[2]
4. Medication assessment, prescription, administration, review, and management
5. Psychological testing[3]
6. Individual, group, family, and/or child therapy
7. Behavioral management services designed to strengthen behavioral self-control, reduce maladaptive behaviors, and improve adjustments to environmental changes
8. Physical and occupational evaluation and therapy
9. Hearing, speech, and language evaluation and therapy
10. Health assessment and enhanced health services which may include nursing, nutrition, hygiene, health promotion, and health education as it relates to psychiatric care
11. Nursing home monitoring/screening

[1] Service planning should be person-centered and culturally competent, and should include contingency planning for changes in recipient circumstances, as well as life-stage transition planning (from late teens to adulthood; from middle-age to geriatric; and for end-of-life issues). Service assessment and delivery should be provided by age-appropriate specialists, and family-centered planning should be utilized for minor recipients, within the confines of applicable state law and appropriate confidentiality practices.

[2] Assessing recipient clinical status including: presenting problem; relevant recipient and family histories; personal strengths and weaknesses; and mental status examination.

[3] With the use of objective or projective standardized instruments to measure intelligence, mental abilities, attitudes, motives, traits and behaviors for purpose of psychodiagnosis, as given by a licensed psychologist.

12. Other assessments, including follow-up of closed cases (adults and minors)

B. Emergency Services
   1. Crisis line, with 24-hour, 7-day-per-week availability
   2. Crisis assessment and intervention

C. Inpatient Psychiatric Services
   1. Acute
   2. Continuous

D. Intensive Support to Maintain Community Tenure
   1. Extended observation beds in a hospital setting for up to 23 hours of evaluation and/or stabilization prior to service selection and possible recipient transfer to another service
   2. Partial hospitalization
   3. Crisis stabilization that combines community-based treatment and support provided to persons in crisis as an alternative to hospital emergency room services and/or inpatient psychiatric care
   4. Intensive outpatient therapy[4]
   5. Diversion program from entering or returning to juvenile justice centers and/or jails
   6. Home-based services
   7. Other services to special populations at risk
      a. Juvenile and criminal justice systems
      b. Homeless shelters
      c. Foster care

E. Housing Services
   1. Crisis residential
   2. Specialized and general (licensed) residential
   3. Semi-independent and supported independent

F. Targeted Support for Community Inclusion and Integration
   1. Case management
   2. Assertive Community Treatment (ACT)
   3. Community treatment team (similar to ACT, with provider team sharing responsibility for multiple community-based services to a recipient, but the client is not in Medicaid)
   4. Community living training and support
   5. Skill-building assistance
   6. Integrated employment services, including older minors and seniors
   7. Family skills development
   8. Respite care
   9. Housing financial aid

[4] A structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least four hours of treatment per week.

10. Wraparound service to minors that is multiple community-based treatment and support for a minor and his/her family, delivered through collaborative inter-agency planning and implementation
11. School-based and supported education services
12. Mentoring and behavioral aid by a trained paraprofessional regarding activities of daily living such as shopping, banking, bill-paying, etc.

G. Psychosocial Rehabilitation and Recovery
   1. Day programs
   2. Clubhouse programs
   3. Peer-delivered/operated support such as the Schizophrenics Anonymous self-help program

H. Transportation
   1. Transport to mental health appointments/treatment
   2. Transport to other medical appointments
   3. Transport related to activities of daily living such as grocery shopping, prescriptions, banking
   4. Transport to employment

II. *Systems Coordination*

A. Coordination and/or Joint Programming with Other Human Service Systems
   1. Primary medical physician
   2. Substance abuse, including specialty care for dually diagnosed MI/SA
   3. Developmental disability, including specialty care for dually diagnosed MI/DD
   4. Family Independence Agencies
   5. Aging networks
   6. Multi-Purpose Collaborative Bodies that are state-sanctioned human service agency consortiums, at county or multi-county levels, which engage in collaborative efforts to improve children's services and outcomes
   7. Community-based supportive housing coalitions

III. *Administrative Support*

A. Constituent Services
   1. Orientation of new consumers
   2. Information for families
   3. Consumer participation in planning, program development, and performance review, in addition to consumer involvement in governance
   4. Consumer appeals, grievances, rights
   5. Advocacy and education

IV. *Prevention*

A. Interventions Targeted to At-Risk Youth[5]

1. Parent training
2. Child and adolescent training
3. School programming/services
4. Child care programming/services
5. Other

[5] Should include restoration of appropriations for prevention services demonstration (pilot) function within mental health section of Department of Community Health budget.